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BY TELEFAX **PRIVILEGED & CONFIDENTIAL**

22nd March 1989

Mr.Mikko Tulokas,
Tulokas & Binomaa,
Helsinki,
Finland.

and

Mr. Finn Berg,
Rettig Group,
Sinikalliontie 5,
SF-02630 Espoo 63, Finland.

Dear Mikko and Finn,

At the meeting Monday in London, you both suggested that it might be useful if I tried to explain a bit more the industry position on the causation issue, as it affects the terminology used in papers with courts. Because I wanted to get back to you right away, I am sending this letter with a first try at meeting your needs.

I should mention first that we have acknowledged without hesitation that smoking is a "risk factor" in lung cancer, emphysema and heart disease. By this we agree that epidemiological studies indicate that people who smoke have an increased statistical risk of developing these diseases. However, as you know, we continue to maintain that smoking has not been scientifically established to be the cause of these diseases in general, or most important for litigation such as Aho, in any given individual. We, therefore, try very hard to avoid any statement or terminology that can be read as an admission that we agree smoking has been established as a cause.

It may be helpful to summarise some of the reasons for this position:

(1) It remains a scientific fact that no one has been able to identify the mechanism that causes a cell to become cancerous or that causes lung tissue to become emphysematous. Even with chemicals that have been found to invariably cause cancer in laboratory animals, no one can say exactly what happens, despite the millions of dollars that have been spent on research.

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(2) Similarly, there is no consensus on what it is in cigarette smoke that causes cancer or emphysema. While a number of chemical compounds found in smoke have been labelled by agencies like IARC as "carcinogens" or "suspected carcinogens", there is no consensus which ones are to blame. During the 1950's and 1960's, for example, benzpyrene was widely blamed: a number of leading scientists later pointed out that it is not present in significant enough quantities. I will send you a recent article by Doll and Peto, two of the leading anti-tobacco scientists candidly acknowledging that the identity of the "bad actors" is still a mystery. The same is true for emphysema.

(3) Under traditionally accepted scientific criteria, a substance such as cigarette smoke is considered to be a proven cause of disease if (1) it consistently causes the disease in laboratory animals exposed only to the suspected cause; or (2) all data from humans are consistent. On point (1), hundreds of experiments involving inhalation of cigarette smoke by laboratory animals have consistently failed to induce lung tumors of the kind found in humans. The same is generally true for laryngeal cancer and emphysema, although the situation is not quite as simple.

On point (2), there are some very significant inconsistencies in the human data. Most important is the fact that all of the diseases blamed on smoking also occur in people who have never smoked. Also, only a small fraction of all smokers develop lung cancer, emphysema or heart disease. In addition, the epidemiological studies showing increased cancer risk also frequently contain inconsistencies and/or variations that have never been satisfactorily explained. To cite a couple of examples, (i) even though smoking rates in Japan are much higher than the US or UK, lung cancer is much less common: The reverse is true in the UK. (ii) laryngeal cancer rates have remained virtually unchanged in the US and Scandinavia throughout the 20th century even though smoking rates have varied considerably.

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(4) "Lung cancer" and "emphysema" are both general terms that lump together a number of different diseases. The statistical association, if any, of the different types with smoking varies widely. One important example is adenocarcinoma, a type of lung cancer that is weakly associated, at most, with smoking. I understand that recent studies are finding that it is becoming much more common.

Because of these kinds of anomalies, I think it is fair to say that experts who say smoking has been "proven" to be a cause are in fact stating an opinion or a presumption based on epidemiology and, when they are confronted on the witness stand with our evidence, they can be forced to admit they cannot fully support their opinion. In the smoking and health litigation, our experience has been that it is very important to keep this option open by maintaining that causation has not been established and avoiding any statement that can be read as an admission to the contrary.

The principal reasons, in my judgment, to keep the causation issue open are these: Nearly every judge or jury has come to believe that causation has been established and only the tobacco fights on the issue. In addition, most people greatly over-estimate the risk. (In the US, for example, most people put a smoker's risk of developing lung cancer at about 50%, far above the true US risk of about 5%). These beliefs inevitably spill over into an assumption that the cancer in a plaintiff like Mr.Aho is probably due to smoking.

In our experience, an effective presentation of the unexplained inconsistencies usually will not persuade a judge or jury that smoking does not cause cancer or other diseases, but it makes people realise three important points: (1) the situation is much more complex than they had assumed; (2) the risks are lower than they had assumed and (3) the industry did have a basis for the kinds of statements Prof.Aurejarvi has been using against us. Equally important, it makes people much more receptive to evidence that the plaintiff's medical condition is due to other factors.

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At the meeting in London, Mikko also raised the question whether one might say that smoking "contributes" to cancer. The problem with such a position is that one either has cancer or one does not: there is no halfway position in which it can be said that smoking aggravated or contributed to an existing cancer. If one takes the position that smoking contributes to the start of cancer, then in many jurisdictions one has conceded proximate causation. A related problem I should mention is that, if one concedes that smoking contributed to the start of a cancer, one has no scientific way of defending how much it contributed, i.e. putting a cap on tobacco's responsibility.

Having said all this, I should now try to answer the specific question you raised about terminology.

As my earlier comments indicate, in briefs, etc., it is perfectly appropriate to say that smoking is a "risk factor" with respect to all of the diseases Aho claims, and that epidemiological studies have shown a "statistical association" or "increased statistical risk" for smokers. Similarly, it is appropriate - and necessary - to talk about the "well-known risk", the "widely publicised risk", the "common knowledge of the risk", the "alleged hazards", the "claimed dangers", etc: The key point is that the epidemiological studies indicating a statistical association and the widely held belief that smoking is harmful have been common knowledge for many years.

I recognise that there is some inconsistency between our saying that everyone knows about the risk, while saying at the same time that we do not believe the scientific basis for the risk has been proven. But I can assure you that we have found that judges and juries in other countries who have heard the evidence have found the industry position to be reasonable. Accordingly, whenever you use words like "danger", "harm", "detriment", etc. of smoking, I would urge you to include an adjective like "claimed", "alleged", "reported", "widely publicized" etc., in order to maintain the flexibility to argue that the scientific issues have not been resolved.

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I should also mention a couple of practical considerations why it is important to avoid any statement that implies we are admitting that smoking has been proven to be the cause of the diseases in the case. First, such a statement can make it much more difficult to explain and defend the past statements by the industry and Rettig which Prof.Aurejarvi has included in his presentations. Put bluntly, you may open yourself to attacks by Prof.Aurejarvi that Rettig made statements in the past to reassure consumers and sell cigarettes and that Rettig takes a different position now that it is before a court.

Second, it is very difficult to explain why, based on the science, Rettig now takes a different position. Although the smoking and health controversy has grown stronger, the fact remains that there has been no scientific breakthrough that you can point to and say: "This is why we now agree smoking causes or contributes to X disease and was not known 10 years ago".

As I may have mentioned at the London meeting, I have begun to think that it may be good strategy to call one or two of Aurejarvi's expert witnesses early in the defense and confront them with our evidence on these issues. One practical reason is that, at least in our experience, it can be more effective to have a plaintiff's expert admit he does not have all the answers than it is to put on a witness sponsored by the industry. In order to fully evaluate this, we need to assemble the industry's best evidence and put it in an outline you and Rober can review, so that you can make a decision with all the necessary information. It has been done numerous times in other cases, so I will pursue this question with the US lawyers and try to get a clear understanding on who is to do this and by when.

I hope these comments are helpful and I will be happy to discuss them further. Nick Cannar has agreed that our next meeting should be in Helsinki, but I will be happy to come over before then to discuss these issues in more detail.

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In closing, let me emphasize that I fully recognize that each country is different and that we do not need to say something in Helsinki just because it was said in New Jersey. But I can assure you that we have spent hundreds, if not thousands, of hours wrestling with these problems and my goal is to make sure you have the full benefit of the lessons we have learned.

Regards,

James Goold
(Dictated by Mr.Goold and signed
in his absence).

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